MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07345

7360 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Spring
STREET ADDRESS (If rural give location) 2306 Eccleston Street

3. NAME OF DECEASED: (Type or Print) (First) ANTONINO (Middle) (Last) ARDIZZONE

4. DATE OF DEATH: (Month) Aug. (Day) 8 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: January 1, 1886

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bricklayer

10B. KIND OF BUSINESS OR INDUSTRY: Self-employed

11. BIRTHPLACE (State or foreign country): Italy

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank R. Ardizzone

14. MOTHER'S MAIDEN NAME: Mary Abbadessa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 041-07-3593

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 IMMEDIATE CAUSE	(A) Broncho-pneumonia	12 days
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B) Cardio-vascular disease	15 years
	DUE TO (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	C.B.S. associated with circulatory disturbance with cerebral arteriosclerosis, with psychotic reaction.	3 years.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1, 1953 to 8/8, 1954, that I last saw the deceased alive on 8/8, 1954, and that death occurred at 10:05 P.M., from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeldt ADDRESS M.D. Springfield State Hospital DATE SIGNED 8/8/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8/12/54

NAME OF CEMETERY OR CREMATORY Parklawn Cemetery

LOCATION (City, town, or county) (State) Montgomery County, Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 11, 1954

REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR Warner E. Pumphrey ADDRESS 8434 Georgia Ave. Silver Spring, Md.

RECEIVED
AUG 12 1954
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. ... information carefully. The correct age is especially important. Physicians: please write clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07346

7361

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown
LENGTH OF STAY (in this place) Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown
STREET ADDRESS (If rural give location) York Street

3. NAME OF DECEASED: (Type or Print) (First) Roy (Middle) H. (Last) Baker

4. DATE OF DEATH: (Month) August (Day) 14, (Year) 1954

5. SEX: ale

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 23, 1889

9. AGE last birthday 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Callender opr.

10B. KIND OF BUSINESS OR INDUSTRY: Rubber Factory

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Curtis Baker

14. MOTHER'S MAIDEN NAME: Louise Wertz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-03-0087

17. INFORMANT & ADDRESS: Mrs. Mary Baker, Taneytown, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Acute congestive failure c̄ pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 80 min

ANTECEDENT CAUSE (B) DUE TO acute myocardial infarction — 3 hrs

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO Coronary occlusion. — 3½ hrs.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma of larynx (removed c̄ tracheotomy) 10 months

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29 Aug., 1952 to 14 Aug., 1954, that I last saw the deceased alive on 14 August, 1954, and that death occurred at 12:31 A.M. E.D.T. from the causes and on the date stated above.

SIGNATURE Walton E. Stevens M. D. ADDRESS Taneytown, Md. DATE SIGNED 16 August 1954

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Aug. 17, 1954

NAME OF CEMETERY OR CREMATORY Reformed Cemetery

LOCATION (City, town, or county) (State) Taneytown, Maryland

DATE REC'D BY LOCAL REGISTRAR Aug. 16, 1954

REGISTRAR'S SIGNATURE Ethel M Mehring local

24. FUNERAL DIRECTOR ADDRESS C.O.Fuss & Son, Taneytown, Maryland

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AUG 18 1954
BUREAU V. S.

7356

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07347 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY CARROLL — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN WESTMINSTER
LENGTH OF STAY (in this place) 3 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS NONE & BOX ?

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY CARROLL
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN SAME WESTMINSTER
STREET ADDRESS (If rural, give location) BOX ?

3. NAME OF DECEASED: (Type or Print) (First) EDWIN (Middle) J (Last) BECKER

4. DATE OF DEATH (Month) Aug (Day) 6 (Year) 19 54

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: FEB 16 - 1917

9. AGE last birthday: 37 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): WRITING

10b. KIND OF BUSINESS OR INDUSTRY: SPORTS

11. BIRTHPLACE (State or foreign country): BALTIMORE

12. CITIZEN OF WHAT COUNTRY? ~~MD~~ USA

13. FATHER'S NAME: HENRY J. BECKER, SR.

14. MOTHER'S MAIDEN NAME: ELIZABETH A. COOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY No.: NO

17. INFORMANT & ADDRESS: 3803 ROBERT W. BECKER, SOUTHERN CROSS RD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Gunshot wound of head

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home

21c. (City or town) Reisterstown (County) Baltimore (State) Md

21d. TIME (Month) OF INJURY 8 (Day) - 6 (Year) - 54 (Hour) M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR? Self inflicted gunshot wound

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T Thomas M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 8-6-54

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

DATE THEREOF 8/9/54

NAME OF CEMETERY OR CREMATORY Lorraine Park Cem

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 8/10/54

REGISTRAR'S SIGNATURE Harriet Miller mmt

24. FUNERAL DIRECTOR Chas P. Powell

ADDRESS 411 Windsor Mill, Md.

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AUG 11 1954
BUREAU V. S.

7362

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 07348

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town: Sykesville
LENGTH OF STAY (in this place): 11yr. 11months
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN: Baltimore 13,
STREET ADDRESS (If rural, give location): 1624 N. Gay Street

3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles Edward Burgess	August 3 1954

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	7-17-1870	84 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Metal worker	Unk.	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Caleb Henry Burgess	Mary Amanda Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT & ADDRESS
No	Unk.	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a)	Coronary occlusion	1 hour
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)	Arteriosclerosis	years
DUE TO		
(c)	fracture of right hip	13½ hrs.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Psychosis with cerebral arteriosclerosis.	years

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☒ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)
	Hospital	Sykesville	Carroll	Maryland

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While at work ☐ Not while at work ☒	21f. HOW DID INJURY OCCUR?
8 3 1954 5:50 a.m.		Fell on lawn injuring right hip

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Monash M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 8/4/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug 5th 1954	St Peters	Balto. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 5, 1954	C. Harry Weed	Lea G. Cook	1701-03 N Patterson Park Ave

RECEIVED
AUG 9 1954
BUREAU V. S.

7363

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 07349

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 76

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Leonard MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lusby. Westminster
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R7. Washington Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY 1
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 1110 Homewood Ave.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
STEPHEN	PATRICK	CAMPBELL Jr.	Aug.	5	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
M	W	Married	July 28 1894	60 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Lawyer		Baltimore Md	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Stephen P. Campbell Sr	Kate EMMART

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Yes. World War I	None	Mrs. Anne Ditzell, Westminster Md. R7

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Coronary sclerosis
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James T. Marsh M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 8/5/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	8-9-1954	BALTIMORE NATIONAL	BALTO. MD

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8/5/54		J. Walter Conklin	2343 HARFORD RD. BALTO, MD

VS. A15A - 5 - 53

MARYLAND 7364

07350

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

M

1. PLACE OF DEATH COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED STATE: Maryland COUNTY: ---
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural - Sykesville; LENGTH OF STAY (in this place): since 4/2/52	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City (20)
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital	STREET ADDRESS (If rural, give location): Long Beach Road

3. NAME OF DECEASED (Type or Print)	(First) Harvey	(Middle) Noel	(Last) CANNON	4. DATE OF DEATH	(Month) August	(Day) 5	(Year) 1954
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated	8. DATE OF BIRTH: May 11, 1875	9. AGE last birthday: 79 yrs.	If under 1 year: Months — Days —	If under 24 hrs.: Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter	10b. KIND OF BUSINESS OR INDUSTRY: Carpentry	11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? United States				
13. FATHER'S NAME: James Cannon	14. MOTHER'S MAIDEN NAME: Julie Mason						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If year, give war or dates of service) ---	16. SOCIAL SECURITY NO.: unknown	17. INFORMANT AND ADDRESS: Records - Springfield State Hospital					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Bronchopneumonia	1 week
Antecedent cause(s)		more than
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Generalized arteriosclerosis, plus cardiac decompensation.	2 yrs.
	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Psychosis with cerebral arteriosclerosis	2½ yrs.

19a. DATE OF OPERATION: ---	19b. MAJOR FINDINGS OF OPERATION: ---	20. AUTOPSY? Yes ☐ No ☒
21. ACCIDENT SUICIDE HOMICIDE (Specify): ---	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): ---	(CITY OR TOWN) (COUNTY) (STATE) ---
TIME OF INJURY (Month) (Day) (Year) (Hour): --- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐ ---	HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from June 17, 1952, to Aug. 5, 1954, that I last saw the deceased alive on August 5, 1954, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Martin Gross M.D.	Martin Gross, M.D.	Sykesville, Maryland	8/5/54

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	8-7-54	Baltimore	Balto. Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug. 5, 1954	C. Harry Weer	Wm Cook, Inc. 1217 St Paul St.	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07351

7355

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 20 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 5408 Kemmel Avenue

3. NAME OF DECEASED: (First) Jeanette (Middle) B. (Last) Carter

4. DATE OF DEATH: (Month) Aug. (Day) 29 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH: Sept. 20, 1897

9. AGE last birthday: 56 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10B. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John R. Fairbank

14. MOTHER'S MAIDEN NAME: Ida B. Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. NONE

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1 10X

IMMEDIATE CAUSE (A) Cancer of left breast with metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1½ yrs.

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO to right side and gastro intestinal

(C) tract.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Dementia Praecos — 20 yrs. & longer

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1, 1950, to Aug. 29, 1954 that I last saw the deceased alive on Aug. 28, 1954, and that death occurred at 1:10 A M, from the causes and on the date stated above.

SIGNATURE Gertrude Sonnenfeldt M.D. ADDRESS Springfield State Hospital, Sykesville Md. DATE SIGNED 8-29-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF 8/31/54

NAME OF CEMETERY OR CREMATORY Prospect Hill Cem

LOCATION (City, town, or county) (State) Balto md

DATE REC'D BY LOCAL REGISTRAR Sept. 7, 1954

REGISTRAR'S SIGNATURE C. Harry Tiller

24. FUNERAL DIRECTOR Lansdale Funeral Home ADDRESS 7401 Belair Rd

M

I

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07352

7366 CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Carroll
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Sykesville
LENGTH OF STAY (in this place) 27y 2 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 4105 Overlea Ave

3. NAME OF DECEASED: (Type or Print) (First) Lawrence (Middle) B (Last) Costello

4. DATE OF DEATH: (Month) 8 (Day) 8 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8-1-1885

9. AGE: Last birthday: 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Boiler maker

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. R.R.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Costello

14. MOTHER'S MAIDEN NAME: Mary Keady

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebro-vascular accident — Interval Between Onset And Death 24 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) arteriosclerosis — years
DUE TO (c) Prostatic hypertrophy — years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid type

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-22, 1954 to 8-8-, 1954, that I last saw the deceased alive on 8-7, 1954, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Jones M.D. ADDRESS Springfield State Hospital DATE SIGNED 8/9/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8/11/54 NAME OF CEMETERY OR CREMATORY Mount Olivet Cathedral Cem. LOCATION (City, town, or county) (State) 4300 Old Frederick Rd.

DATE REC'D BY LOCAL REGISTRAR 8-9-54 REGISTRAR'S SIGNATURE A. W. Herrick

24. FUNERAL DIRECTOR John J. Cowan & Son ADDRESS 901 Hamburg St.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07353

7357 CERTIFICATE OF DEATH Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville. LENGTH OF STAY (in this place) 2y 10 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) Goode (Last) Coulter
4. DATE OF DEATH: (Month) 8 (Day) 12 (Year) 1954.
5. SEX: female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow
8. DATE OF BIRTH: 1-16-1879
9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): nurse
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Volan Boyd
14. MOTHER'S MAIDEN NAME: Laura Anderson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Myocardial infarct — 12 hr
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) coronary occlusion — 5 days
DUE TO
(c) arteriosclerosis — Years
420.1

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome due to senile changes 4y+ — 4y+.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1 1953, to 8-12, 1954, that I last saw the deceased alive on 8-12, 1954, and that death occurred at 5:10 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Walter H. Sonnenfeldt M.D. Springfield State Hospital 8/12/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Aug 14/54 | NAME OF CEMETERY OR CREMATORY Loudon Park | LOCATION (City, town, or county) Balto. Md (State)

DATE REC'D BY LOCAL REGISTRAR 8-13-54 | REGISTRAR'S SIGNATURE C. W. Hennis

24. FUNERAL DIRECTOR ADDRESS H. Fenby Sons Fun. Co 4905 York Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

07354

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7368 **CERTIFICATE OF DEATH** Reg. Dist. No. 70

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Taneytown
LENGTH OF STAY (in this place) Liftime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Taneytown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Helen (Middle) Eudora (Last) Crapster

4. DATE OF DEATH: (Month) August (Day) 26, (Year) 19 54

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: July 15, 1894

9. AGE last birthday: 60 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housework

10B. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Reindollar

14. MOTHER'S MAIDEN NAME: Laura Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT & ADDRESS: Mrs. Robert Hengst, Thurmont, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSE (S) DUE TO (B) arteriosclerotic heart disease — 5 yrs.

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Essential hypertension — 3 yrs.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLY NG ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 Feb., 1945 to 26 Aug, 1954 that I last saw the deceased alive on 24 Aug ..., 1954, and that death occurred at 6:15 P.M. E.D.T., from the causes and on the date stated above.

SIGNATURE Walter E. Stevens M. D. ADDRESS Taneytown Md DATE SIGNED 26 Aug. 54

23. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

DATE THEREOF: Aug. 29, 1954

NAME OF CEMETERY OR CREMATORY: Piney Creek Presby. Cemetery

LOCATION (City, town, or county) (State): Taneytown, R.D., Md.

DATE REC'D BY LOCAL REGISTRAR: Aug 27, 1954

REGISTRAR'S SIGNATURE: Ethel M Mehring Local

24. FUNERAL DIRECTOR ADDRESS: C.O.Fuss & Son, Taneytown, Maryland

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15—10-53

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MARYLAND 7369

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STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH: COUNTY Carroll County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md
LENGTH OF STAY (in this place) 75 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Carroll COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Md
STREET ADDRESS (If rural, give location) "

3. NAME OF DECEASED (Type or Print) (First) Herbert (Middle) Latourette (Last) Crook

4. DATE OF DEATH (Month) Aug. (Day) 18 (Year) 1954

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH 13 Nov 1878

9. AGE last birthday 75 yrs. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer

10b. KIND OF BUSINESS OR INDUSTRY farmer

11. BIRTHPLACE (State or foreign country) Cathedrale, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Latourette Crook

14. MOTHER'S MAIDEN NAME Emily V. Fryette

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. 219-22-4068

17. INFORMANT AND ADDRESS Wife, Mrs. Crook - Sykesville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac arrest

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) emphysema, [illegible] failure

(c) coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH: 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0

19b. MAJOR FINDINGS OF OPERATION 0

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) 0

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 0 (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) 0 m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Feb, 1954, to Aug, 1954, that I last saw the deceased alive on 18 Aug, 1954, and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE Howard C. Hall MD (Degree or title) ADDRESS Sykesville, Md. DATE SIGNED 18 Aug 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE Aug. 21, 1954

NAME OF CEMETERY OR CREMATORY Springfield

LOCATION (City, town, or county) (State) Sykesville, Md.

DATE REC'D BY LOCAL REG. Aug. 19, 1954

REGISTRAR'S SIGNATURE C. Stacy Weer

24. FUNERAL DIRECTOR C. H. Weer, ADDRESS Sykesville, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07356

7357 **CERTIFICATE OF DEATH** Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 64 Madison St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 64 Madison St.

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) WILFRED HENRY CROUSE

4. DATE OF DEATH: (Month) (Day) (Year) Aug 6 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Jan. 13, 1892
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Miller
10b. KIND OF BUSINESS OR INDUSTRY: Flour & Grain Mill
11. BIRTHPLACE (State or foreign country): Middleburg Carroll Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wilson L. Crouse
14. MOTHER'S MAIDEN NAME: Carrie A. Ruby

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: 217-01-1429
17. INFORMANT & ADDRESS: Mrs Carrie B. Crouse, 64 Madison St. Westminster, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Rheumatoid arthritis 12 yrs ±
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Pleurisy with pleural effusion 4 mos ±

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1942 to Aug 6 1954 that I last saw the deceased alive on Aug 5, 1954 and that death occurred at 12:30 AM from the causes and on the date stated above.

SIGNATURE (Degree or title) Reese Wilkins M.D. ADDRESS Westminster DATE SIGNED 8/6/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Aug 8/54
NAME OF CEMETERY OR CREMATORY Kriders Cemetery
LOCATION (City, town, or county) (State) Rural, Westminster, Md.
DATE REC'D BY LOCAL REGISTRAR 8-6-54
REGISTRAR'S SIGNATURE Hermit H. [illegible]
24. FUNERAL DIRECTOR J. E. Myers, Jr. ADDRESS Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7370

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 13 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Franklin (Last) Cutsail
4. DATE OF DEATH: (Month) Aug. (Day) 30 (Year) 1954

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: 9-14-1869
9. AGE last birthday 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): hospital attendant
10B. KIND OF BUSINESS OR INDUSTRY: Springfield Hospital
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Franklin Cutsail
14. MOTHER'S MAIDEN NAME: Martha?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

IMMEDIATE CAUSE (A) Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs.

ANTECEDENT CAUSE (S) DUE TO (B) Cardio-vascular disease — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerosis — years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Cardiovascular syndrome due to arteriosclerosis — ~~years~~ one year

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-17-, 1954, to 8-30, 1954, that I last saw the deceased alive on 8-29-, 1954, and that death occurred at 4:10 A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenfeldt M. D. ADDRESS Springfield State Hospital DATE SIGNED 8/30/54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-1-54
NAME OF CEMETERY OR CREMATORY Springfield
LOCATION (City, town, or county) (State) Sykesville, Md.

DATE REC'D BY LOCAL REGISTRAR Aug 30, 1954
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Weer & Haight ADDRESS Sykesville, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10-53

SEP 2
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7371

CERTIFICATE OF DEATH

Reg. Dist. No. 07358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Carroll
CITY (If outside corporate limits, write RURAL) OR TOWN (and give nearest town): New Windsor
LENGTH OF STAY (in this place): 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Windsor
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED: (First) M. (Middle) ALICE (Last) DEVILBISS
4. DATE OF DEATH: (Month) Aug. (Day) 27 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: 5/5/1863
9. AGE last birthday: 91 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Isaac Shoemaker
14. MOTHER'S MAIDEN NAME: Margaret Hart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no
(If Yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: none
17. INFORMANT & ADDRESS: M. E. DeVilbiss, New Windsor, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause: (a) Lobar Pneumonia — Interval Between Onset And Death: 3 days.
490X
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 20, 1954, to Aug 27, 1954, that I last saw the deceased alive on Aug 27, 1954, and that death occurred at 1:45 PM, from the causes and on the date stated above.
SIGNATURE (Degree or title): James J. Monat M.D.
ADDRESS: Baltimore Md
DATE SIGNED: 8/27/54

23. BURIAL, CREMATION, REMOVAL (Specify): Private
DATE THEREOF: 8/30/54
NAME OF CEMETERY OR CREMATORY: Pipe Creek Cem.
LOCATION (City, town, or county): Carroll County
(State): Md.

DATE REC'D BY LOCAL REGISTRAR: Aug 28/54
REGISTRAR'S SIGNATURE: Ernest S. Benedict
24. FUNERAL DIRECTOR: D. D. Hartsock & Son
ADDRESS: New Windsor, Md.

RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07359

CERTIFICATE OF DEATH

7358 Reg. Dist. No. 26

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster 27
LENGTH OF STAY (in this place) 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 W. Green St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural give location) 90 W. Green St.

3. NAME OF DECEASED: (Type or Print) (First) EMORY (Middle) CARROLL (Last) EBAUGH

4. DATE OF DEATH: (Month) Aug. (Day) 12 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: Sept. 17, 1872

9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): School teacher

10b. KIND OF BUSINESS OR INDUSTRY: public Schools

11. BIRTHPLACE (State or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jeremiah Ebaugh

14. MOTHER'S MAIDEN NAME: Martha Ann Richards

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 215-18-2485

17. INFORMANT & ADDRESS: Mrs. Emory C. Ebaugh 90 W. Green St. Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 3 weeks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO arteriosclerosis ± 5 yrs
(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Heart block ± 1½ yrs

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1954 to Aug 12, 1954, that I last saw the deceased alive on Aug 12, 1954, and that death occurred at 8 P.M. from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Reese Wilkins M.D. Westminster Md 8/13/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug. 14/1954 NAME OF CEMETERY OR CREMATORY Carrollton Church of God LOCATION (City, town, or county) (State) Md. 54

DATE REC'D BY LOCAL REGISTRAR 8-16-54 REGISTRAR'S SIGNATURE Bernard Wilson

24. FUNERAL DIRECTOR J. E. Myers Jr. ADDRESS Westminster Md.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 16 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07360

7372 CERTIFICATE OF DEATH

Reg. Dist. No. 80

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Carroll MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor; LENGTH OF STAY (in this place) 4 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Windsor; STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) BEULAH (Middle) S. (Last) ENGLAR

4. DATE OF DEATH: (Month) Aug. (Day) 22 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 29-1898

9. AGE last birthday: 55 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Milton T. Haines

14. MOTHER'S MAIDEN NAME: Mary Wood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no; (If Yes, give war or dates of service) no

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: J. F. Englar New Windsor, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: 3 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/22/54 19..., to 8/22/54, 19..., that I last saw the deceased alive on 8/22/54 19..., and that death occurred at 8:35 AM., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

M. E. Robertson M.D. New Windsor. Md 8/23/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 8/24/54 NAME OF CEMETERY OR CREMATORY Pipe Creek Cem LOCATION (City, town, or county) Carroll County, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Aug 23/54 REGISTRAR'S SIGNATURE Grace E. Benedict

24. FUNERAL DIRECTOR ADDRESS D. D. Hartzler & Son New Windsor, Md.

VS. A15

RECEIVED
AUG 25 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

07361

7373

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Taneytown
LENGTH OF STAY (In this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. 1

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Taneytown
STREET ADDRESS (If rural, give location) R.D. 1

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Edward (Last) Feese

4. DATE OF DEATH: (Month) Aug. (Day) 14 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 7/3/1869

9. AGE last birthday: 85 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fruit Grower & Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Self Employed

11. BIRTHPLACE (State or foreign country): Millmount Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Not Known

14. MOTHER'S MAIDEN NAME: Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Ellen M Richard Taneytown Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
427.1 Immediate cause	(a) Coronary Artery Occlusion	16 days
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary Arteriosclerosis	10 yrs.
	(c) Generalized Arteriosclerosis	20 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Myocarditis and Degeneration — 10 yrs.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1954, to Aug. 13, 1954, that I last saw the deceased alive on Aug. 13, 1954, and that death occurred at 12:15 a. m., from the causes and on the date stated above.

SIGNATURE: R. S. McVaugh (Degree or title) M.D. ADDRESS: Taneytown, Md. DATE SIGNED: Aug. 14, 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 8/17/54 — NAME OF CEMETERY OR CREMATORY: Wellys Cemetery — LOCATION (City, town, or county) (State): South Long 3rd Ld. 2

DATE REC'D BY LOCAL REG.: Aug. 14. 1954 — REGISTRAR'S SIGNATURE: Ethel M. Mehring Local — 24. FUNERAL DIRECTOR: Walter J. Hess — ADDRESS: Waynesboro, Pa

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information ■efully. The co■ct ■e is ■pecially important. Physicians: please write the causes of death clearly and le■bly.

MARGIN RESERVED FOR BINDING

AUG

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07362

7374 CERTIFICATE OF DEATH Reg. Dist. No.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural-Westminster
LENGTH OF STAY (in this place) 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural- Westminster
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Samuel (Middle) Joseph (Last) Flickinger

4. DATE OF DEATH: (Month) Auguat (Day) 16, (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Nov. 2, 1857

9. AGE last birthday: 96 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Carroll Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frederick Flickinger

14. MOTHER'S MAIDEN NAME: Deborah Winters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Mrs. Thomas Weishaar, Westminster, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Cardio Vascular Disease — Interval Between Onset and Death: 4-5 years

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 1950, to Aug 16, 1954, that I last saw the deceased alive on August 16, 1954, and that death occurred at 10:15 P. m., from the causes and on the date stated above.

SIGNATURE James J. Monad (DEGREE OR TITLE) M. D. ADDRESS Westminster Md DATE SIGNED 8/17/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF Aug. 19, 1954 NAME OF CEMETERY OR CREMATORY Baust Cemetery LOCATION (City, town, or county) (State) Tyrone, Carroll Co., Md.

DATE REC'D BY LOCAL REG. 8/23/54 REGISTRAR'S SIGNATURE Harriett Miller

24. FUNERAL DIRECTOR ADDRESS C.O.Fuss & Son, Taneytown, Maryland

RECEIVED
AUG 24 1954
BUREAU V

7375 07363

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville
LENGTH OF STAY (in this place) since 5/10/38
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Garrett
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville
STREET ADDRESS (If rural, give location) RFD

3. NAME OF DECEASED (Type or Print) (First) Oscar (Middle) - (Last) FRIEND
4. DATE OF DEATH (Month) August (Day) 25 (Year) 1954

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower
8. DATE OF BIRTH May 21, 1871
9. AGE last birthday 83 yrs. If under 1 year: Months - Days - If under 24 hrs.: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner and farmer
10b. KIND OF BUSINESS OR INDUSTRY Mining and farming
11. BIRTHPLACE (State or foreign country) Friendsville, Maryland
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME Andrew C. Friend
14. MOTHER'S MAIDEN NAME Mary S. Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) ---
16. SOCIAL SECURITY NO. unknown
17. INFORMANT AND ADDRESS Records of Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
420.0 Immediate cause	(a) Bronchopneumonia	3 days
Antecedent cause(s)	(b) Diabetes mellitus	2 yrs.
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerotic heart disease	about 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia, paranoid type — 48 yrs.

19a. DATE OF OPERATION ---
19b. MAJOR FINDINGS OF OPERATION ---
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) ---
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) --- m.
INJURY OCCURRED While at Work ☐ Not While At work ☐ ---
HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from Oct. 27, 1949, to Aug. 24, 1954, that I last saw the deceased alive on Aug. 24, 1954 and that death occurred at 1:50 A. m., from the causes and on the date stated above.

SIGNATURE Florian Nadolski (Degree or title) ADDRESS Florian Nadolski, M.D. Sykesville, Maryland DATE SIGNED 8/25/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 8-28-54
NAME OF CEMETERY OR CREMATORY Blooming Rose
LOCATION (City, town, or county) (State) Friendsville, Md.

DATE REC'D BY LOCAL REG. Aug. 26, 1954
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR Weer & Haight - Sykesville, Md. ADDRESS Luther H. Haight

MARGIN RESERVED FOR BINDING

I

AUG 27
BUREAU V. S.

7376 07364

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Greenmount

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural, give location) Greenmount

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Horatio R. Garrett
4. DATE OF DEATH (Month) (Day) (Year) 8 - 18 - 1954

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH 3-1-66
9. AGE last birthday 88 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Carroll co md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Daniel Garrett
14. MOTHER'S MAIDEN NAME Miranda Ritter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT AND ADDRESS Arthur A. Garrett Greenmount

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Arterio-Sclerotic C-V Disease — 5 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Retro-Peritoneal Tumor — 14 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to Aug. 18, 1954, that I last saw the deceased alive on Aug. 18, 1954, and that death occurred at 2:30 pm., from the causes and on the date stated above.

SIGNATURE Mr Porterfield (Degree or title) M.D ADDRESS Hampstead, md DATE SIGNED 8/19/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 8-21-54
NAME OF CEMETERY OR CREMATORY Manchester Cem.
LOCATION (City, town, or county) (State) Manchester Carroll co md

DATE REC'D BY LOCAL REG. Aug. 20/54
REGISTRAR'S SIGNATURE Mrs. Wm S. Denner
24. FUNERAL DIRECTOR R B Wink ADDRESS Manchester Md

MARGIN RESERVED FOR BINDING

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RECEIVED
AUG 25 1954
BUREAU V. S.

07365

MARYLAND 7377

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

M

MARGIN RESERVED FOR BINDING

1

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville; LENGTH OF STAY (in this place) since 6/15/53	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural, give location) 67 Frost Avenue

3. NAME OF DECEASED (Type or Print) (First) Leroy (Middle) - (Last) GERLACH				4. DATE OF DEATH (Month) August (Day) 29 (Year) 1954	
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower	8. DATE OF BIRTH Oct. 27, 1889	9. AGE last birthday 64 yrs.	If under 1 year Months - Days - If under 24 hrs. Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10b. KIND OF BUSINESS OR INDUSTRY Unk -	11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY United States
13. FATHER'S NAME Charles Henry Gerlach			14. MOTHER'S MAIDEN NAME Nellie Mary Castell		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) ---		16. SOCIAL SECURITY NO. unknown	17. INFORMANT AND ADDRESS Records of Springfield State Hospital		

4

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Lung abscess with perforation to the pleura	about 24 hrs.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Bronchopneumonia - right side	10 days
	(c) ---	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	General Paresis	about 10 yrs.

19a. DATE OF OPERATION ---	19b. MAJOR FINDINGS OF OPERATION ---	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) ---	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---	(CITY OR TOWN) --- (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) --- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ---

22. I hereby certify that I attended the deceased from July 24, 1953, to Aug. 28, 1954, that I last saw the deceased alive on Aug. 28, 1954, and that death occurred at 4:15 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
Florian Nadolski	Florian Nadolski, M.D. Sykesville, Md.	8/30/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 9-1-54	NAME OF CEMETERY OR CREMATORY Allegany	LOCATION (City, town, or county) Frostburg, Md (State)
DATE REC'D BY LOCAL REG. Aug. 30, 1954	REGISTRAR'S SIGNATURE C. Harry Weir	24. FUNERAL DIRECTOR Weir & Haight - Sykesville, Md.	ADDRESS

U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7377-a

CERTIFICATE OF DEATH

Reg. Dist. No. 07366 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 5 mo 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Randlestown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Beal (Middle) — (Last) Gosnell

4. DATE OF DEATH: (Month) aug (Day) 20 (Year) 19 54

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: 1-31-1862

9. AGE last birthday: 92 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Blacksmith

10b. KIND OF BUSINESS OR INDUSTRY: Own shop

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) nuk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia (terminal) — Interval Between Onset And Death 20 hrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) cardio-vascular disease — years

DUE TO

(c) Arteriosclerosis — years

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome due to senile changes.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-13, 19 54, to 8-20, 19 54, that I last saw the deceased alive on 8-19, 19 54, and that death occurred at 9:25 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Walter H. Sonnenstrahl M.D. ADDRESS Springfield State Hospital DATE SIGNED 8/20/54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Aug. 22, 1954 NAME OF CEMETERY OR CREMATORY Howard Chapel LOCATION (City, town, or county) Long Corner, (State) Howard Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 22, 1954 REGISTRAR'S SIGNATURE C. Harry Weer

24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.

VS. A15

RECEIVED
AUG 25 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07367

7378

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Md. LENGTH OF STAY (in this place) 14 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Monty
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Md.
STREET ADDRESS (If rural give location) 8812 Second Ave.

3. NAME OF DECEASED (Type or Print) (First) Elsie (Middle) May (Last) Grinder
4. DATE OF DEATH: (Month) Aug 1st (Day) (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed
8. DATE OF BIRTH: May 18-1888
9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Bookkeeper
10b. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (State or foreign country): Washington DC
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. H. Cissell
14. MOTHER'S MAIDEN NAME: Emma Bradley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: Unk.
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Broncho Pneumonia — Interval Between Onset And Death 1 week

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Chr. Myocarditis — 4 yrs

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 12, 1951, to Aug 1st 1954, that I last saw the deceased alive on Aug 2, 1954 and that death occurred at 11:05 P.M. from the causes and on the date stated above.

SIGNATURE M N Martin (Degree or title) M D ADDRESS Sykesville Md DATE SIGNED Aug 1st 54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Aug 5/54
NAME OF CEMETERY OR CREMATORY Congressional Cemt
LOCATION (City, town, or county) Washington DC (State)

DATE REC'D BY LOCAL REGISTRAR Aug. 2, 1954
REGISTRAR'S SIGNATURE C. Harry Wiser
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 517 11th St S.E. Wash D.C

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

AUG 4
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

7379 — 2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07368 — Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Silver Run, R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Silver Run, R. F. D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. --
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: John Thomas Harrison

3.(b) Social Security Number: 212-07-6055

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Sarah E. Harrison
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 21, 1872

8. AGE: Years	Months	Days	If less than one day
81			..... hrs. ..... min.

9. Birthplace: Montgomery Co., Md. (Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Grocery

FATHER
12. Name: ? Harrison
13. Birthplace: unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. James E. Norman
Address: 3400 Windsor Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/54 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS WPB
Address: North & Pa. Aves., Balto. 16, Md.

19. 8/29/54 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/30/54, 19..., at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/30, 19 54, to 8/30, 19 54, and that I last saw him alive on 8/30/54, 19...

Immediate cause of death: Acute Coronary Thrombosis — DURATION: 3 hours.
Due to: Severe Cataract Edema — 10 yrs.
Due to: Mitral Regurgitation — 10 yrs.
Other conditions: .....
(Include pregnancy within 3 months of death)

Major findings of operations: .....
Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Thurston Bean M. D.
Address: Westminster, Md. Date signed: 8/30/54

07369

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7380

CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH: COUNTY Carroll MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown R#1 X

LENGTH OF STAY (in this place) 15 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Carroll

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown

STREET ADDRESS (If rural give location) W.Baltimore St

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) G (Last) Hill

4. DATE OF DEATH: (Month) Aug. (Day) 27 (Year) 1954.

5. SEX: M

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widower

8. DATE OF BIRTH: June 6,1873

9. AGE last birthday 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired fireman

10B. KIND OF BUSINESS OR INDUSTRY: boiler

11. BIRTHPLACE (State or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Adelaide Hill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Joseph G.Hill Jr., Taneytown,Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSE (B) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/25, 1954, to 8/27, 1954, that I last saw the deceased alive on 8-26, 1954, and that death occurred at 8 10 AM, from the causes and on the date stated above.

SIGNATURE J. H Legg M. D. ADDRESS Union Bridge Md DATE SIGNED 8-28-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Aug.30-'54

NAME OF CEMETERY OR CREMATORY St.Joseph's

LOCATION (City, town, or county) (State) Taneytown,Md.

DATE REC'D BY LOCAL REGISTRAR Aug 28,1954

REGISTRAR'S SIGNATURE Ethel M Mehring Local

24. FUNERAL DIRECTOR C.O.FUSS & SON ADDRESS Taneytown,Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

AUG
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07371

7359

CERTIFICATE OF DEATH

Reg. Dist. No. 2-6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Westminster
LENGTH OF STAY (in this place) 60 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 88 E. Main

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westminster
STREET ADDRESS (If rural, give location) 88 E. Main

3. NAME OF DECEASED: (Type or Print) (First) JOSEPHINE (Middle) SARAH (Last) KEEFER

4. DATE OF DEATH: (Month) August (Day) 31 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Dec. 3, 1873

9. AGE last birthday: 80 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Gettysburg, Pa.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Silas Martin

14. MOTHER'S MAIDEN NAME: Loritta Shorb

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: William M. Keefer 88 E main Westminster, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a)	Coronary Occlusion	Few minutes
	DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	Cardio-vascular dis. with hypertension	10 years
	DUE TO		
	(c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 15, 1946, to 8-30, 1954, that I last saw the deceased alive on 8-29, 1954, and that death occurred at 9:40 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

J. C. Billingslea M.D. Westminster, Md. 8-31-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Sept 2-1954

NAME OF CEMETERY OR CREMATORY Westminster Cemetery

LOCATION (City, town, or county) Westminster (State) Md.

DATE REC'D BY LOCAL REG. Sept 1954

REGISTRAR'S SIGNATURE Hazel Miller

24. FUNERAL DIRECTOR H. Bankert & Son Westminster, Md.

SEP 2
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07372

7381 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville ✓
LENGTH OF STAY (in this place) 39 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hos. 15

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taylorsville ✓
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) M. (Last) Kronning
4. DATE OF DEATH: (Month) Aug. (Day) 28 (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: July 4, 1872
9. AGE last birthday 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Rigler
14. MOTHER'S MAIDEN NAME: Ava Adolph
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No. (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE	(A) Cerebral hemorrhage	2 days
ANTECEDENT CAUSE (B)	DUE TO (B) Generalized arteriosclerosis	years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (C) resulting in mid thigh amputation of left lower extremity	2 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	Dementia precox hebephrenic type	39 years

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐
21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 15 1950 to Aug. 28, 1954, that I last saw the deceased alive on Aug. 28, 1954, and that death occurred at 8:40 P.M., from the causes and on the date stated above.

SIGNATURE Gertrud Sonnenfeldt, M.D. ADDRESS Springfield State Hospital, Sykesville Md. DATE SIGNED 8-28-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 8-31-54
NAME OF CEMETERY OR ~~CREMATORY~~ Taylorsville Cemetery
LOCATION (City, town, or county) (State) Carroll Co, Maryland
DATE REC'D BY LOCAL REGISTRAR Aug. 20, 1954
REGISTRAR'S SIGNATURE C. Harry Wine
24. FUNERAL DIRECTOR C. M. Waltz ADDRESS Winfield, Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15—10-53

7382 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

07373

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
LENGTH OF STAY (in this place) 12 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hampstead
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) GLADYS (Middle) E (Last) LEISTER

4. DATE OF DEATH (Month) Aug (Day) 8 (Year) 1954

5. SEX F

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) [illegible]

8. DATE OF BIRTH Dec 4 1904

9. AGE last birthday 49 yrs. If under 1 year Months / Days If under 24 hrs. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) [illegible]

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David Thompson

14. MOTHER'S MAIDEN NAME Mary R Tanney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) N

16. SOCIAL SECURITY NO. 214-20-0427

17. INFORMANT AND ADDRESS [illegible], Fleetwood, Upper Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Carcinomatosis	6 mo
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Carcinoma of Ovary	2 yrs
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION June, 1954

19b. MAJOR FINDINGS OF OPERATION Carcinoma of Ovary c̄ Metastases

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1954, to Aug. 8, 1954, that I last saw the deceased alive on Aug. 8, 1954, and that death occurred at 5:15 p.m., from the causes and on the date stated above.

SIGNATURE M. C. Porterfield (Degree or title) M.D ADDRESS Hampstead, Md DATE SIGNED 8/9/54

23. BURIAL, CREMATION REMOVAL (Specify) [illegible]

DATE THEREOF Aug 11-1954

NAME OF CEMETERY OR CREMATORY Hampstead

LOCATION (City, town, or county) Carroll Co (State) Md

DATE REC'D BY LOCAL REG. 8/9/54

REGISTRAR'S SIGNATURE Henry Wells

24. FUNERAL DIRECTOR Eric Crispton, Hampstead Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

AUG 11
V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7383 07374

CERTIFICATE OF DEATH

Item 9 Film G169 9- 9-54 et

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll Md. MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) Unk.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 2880 Harford ave

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) Florence (Last) Long
4. DATE OF DEATH: (Month) Aug (Day) 11 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 9/2/1879
9. AGE last birthday: 74 yrs. 7/5/1
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Unk.
10b. KIND OF BUSINESS OR INDUSTRY: Unk.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Peter Robert Massicott
14. MOTHER'S MAIDEN NAME: Anna McGreevy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service) –
16. SOCIAL SECURITY NO.: Unk.
17. INFORMANT & ADDRESS: Joseph Preston Long

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X

Immediate cause (a) cerebro-vascular accident — Interval Between Onset And Death: several hours

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Generalized arteriosclerosis — many years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Senile psychosis — many years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/15/, 1954, to 8/10/, 1954, that I last saw the deceased alive on 8/10/, 1954, and that death occurred at 1445 am from the causes and on the date stated above.

SIGNATURE A. Lelizbo M.D. (Degree or title) on 8/11/54 ADDRESS Springfield Hosp. Md. DATE SIGNED 8/11/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Aug. 14-1954
NAME OF CEMETERY OR CREMATORY St Johns Cemetery
LOCATION (City, town, or county) Westminster (State) Md.
DATE REC'D BY LOCAL REGISTRAR Aug. 12, 1954
REGISTRAR'S SIGNATURE C. Harry Weer
24. FUNERAL DIRECTOR H Bankard & Son Westminster, Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
AUG 16
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07375

7384

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville; LENGTH OF STAY (in this place) 2months15days	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11,
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET ADDRESS (If rural give location) 909 West 38th Street

3. NAME OF DECEASED: (Type or Print) (First) Lewis (Middle) Edward (Last) Long

4. DATE OF DEATH: (Month) August (Day) 3 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	January 3, 1872	82 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Cotton Mill Worker	None	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
William Lewis Long	Rebecca Neil

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No			Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary infarction — Interval Between Onset And Death: 5 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease — MANY yrs

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-18, 1954, to 8-3-, 1954, that I last saw the deceased alive on 8-3, 1954, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Ray H. Hayes, M.D. ADDRESS Springfield State Hospital DATE SIGNED 8- -54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 6, 1954	Woodlawn Cemetery	Woodlawn, Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-4-54	A. W. Hedrick	Wm J. Tickner & Sons, Inc., North & PA. Aves.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

7385

07376

MARYLAND STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY ~~Baltimore~~ Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Finksburg
LENGTH OF STAY (in this place) 7 wks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Grimes nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN miller
STREET ADDRESS (If rural, give location) RD # 1

3. NAME OF DECEASED (Type or Print) (First) Daniel (Middle) P. (Last) Miller
4. DATE OF DEATH (Month) 8 (Day) 6 (Year) 1954

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower
8. DATE OF BIRTH 11-11-69
9. AGE last birthday 84 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY own farm
11. BIRTHPLACE (State or foreign country) Carroll co md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Miller
14. MOTHER'S MAIDEN NAME Catherine Kenney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT AND ADDRESS Mr. Wm. Reese, Alesia Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	5/31/54
Antecedent cause(s)	(b) Hypertension	3 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Arteriosclerosis	5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 2, 1951, to Aug 6, 1954, that I last saw the deceased alive on Aug 6, 1954, and that death occurred at 7:05 p.m., from the causes and on the date stated above.

SIGNATURE W. H. Foard (Degree or title) M.D. ADDRESS Manchester Maryland DATE SIGNED 8/7/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 8-9-54
NAME OF CEMETERY OR CREMATORY Black Rock Cem.
LOCATION (City, town, or county) (State) Linepoint RD # Carroll co md

DATE REC'D BY LOCAL REG. 8-11-54
REGISTRAR'S SIGNATURE Harriet Miller
24. FUNERAL DIRECTOR R B Wink ADDRESS Manchester md.

RECEIVED
AUG 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07377

7386 **CERTIFICATE OF DEATH**

Reg. Dist. No. 70

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg X

LENGTH OF STAY (in this place): lifetime

HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Middleburg

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Vergie	Gertrude	Miller	August	25,	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	Nov. 8, 1894	59 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework	Own home	Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Humbert	Martha Yingling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
no	none	Mr. Franklin E. Miller, Middleburg, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Leucorrhoea	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arteriosclerosis	
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 19 1953, to Aug 25, 1954, that I last saw the deceased alive on Aug 25, 1954, and that death occurred at 5:10 P.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
J. H. Legg	M D	Union Bridge Carroll Md	

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 29, 1954	Methodist Cemetery	Middleburg, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Aug 27, 1954	Ethel M Mehring Asst	C.O.Fuss & Son, Taneytown, Maryland	

RECEIVED
AUG 1 1954
BUREAU U. S.

MARYLAND 7387 07378

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY CARROLL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Sykesville
LENGTH OF STAY (in this place) 4 mos. 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Montgomery
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bethesda
STREET ADDRESS (If rural, give location) 6008 Cobalt Road, Woodacres, Wash. 16.

3. NAME OF DECEASED (Type or Print): (First) CLAUDE (Middle) LEGRAND (Last) MOODY

4. DATE OF DEATH: (Month) 8 (Day) 19 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 3/6/72

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - banker

10b. KIND OF BUSINESS OR INDUSTRY: Unk-

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nick Moody

14. MOTHER'S MAIDEN NAME: Charity ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: Unk-

17. INFORMANT AND ADDRESS: Record, Springfield State Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary occlusion — several hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Cerebral arteriosclerosis — 3 years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction — 3 years

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/10 ., 1954 to 8/19, 1954 that I last saw the deceased alive on 8/19, 1954, and that death occurred at 8:55 A DST m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) M. D. ADDRESS Sykesville, Maryland DATE SIGNED 8/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 8-19-54 | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) Bethesda, (State) Md.

DATE REC'D BY LOCAL REG. Aug. 19, 1954 | REGISTRAR'S SIGNATURE C. Harry Weed

24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Bethesda, Md

RECEIVED
AUG 25 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07379

CERTIFICATE OF DEATH

7388

Reg. Dist. No. 80

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor Rural
LENGTH OF STAY (in this place) years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Carroll
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Windsor Rural
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) ALLEN (Last) NUGENT

4. DATE OF DEATH: (Month) Aug (Day) 29 (Year) 1954

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Nov 17-1888

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): labour

10b. KIND OF BUSINESS OR INDUSTRY: by day

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Columbus Nugent

14. MOTHER'S MAIDEN NAME: Catherine Nugent

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: 215-26-1140

17. INFORMANT & ADDRESS: Daisy Nugent New Windsor, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hypertensive Cardio Vascular Disease — Interval Between Onset And Death 5 yrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1, 1948 to Aug 29, 1954, that I last saw the deceased alive on Aug 29, 1954, and that death occurred at 12:45 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) M. E. Robertson M.D. ADDRESS New Windsor, Md. DATE SIGNED Aug 29, 1954

23. BURIAL, CREMATION, REMOVAL, (Specify) Burial DATE THEREOF Sept 1-1954 NAME OF CEMETERY OR CREMATORY White Rock Cemetery LOCATION (City, town, or county) Sykesville R.D. (State) Md.

DATE REC'D BY LOCAL REGISTRAR Aug 31/54 REGISTRAR'S SIGNATURE Ernest S Bondet

24. FUNERAL DIRECTOR D D Hartzler & Sons ADDRESS New Windsor Md

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07380

MARYLAND 7389

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
LENGTH OF STAY (in this place) 1 month
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 6162 Cardiff Avenue

3. NAME OF DECEASED (Type or Print) (First) Anna (Middle) (Last) O'Brien

4. DATE OF DEATH (Month) August (Day) 1 (Year) 1954

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Unk.
8. DATE OF BIRTH 1882
9. AGE last birthday 72 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.
10b. KIND OF BUSINESS OR INDUSTRY Unk.
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Patrick ?
14. MOTHER'S MAIDEN NAME Mary ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. Unk.
17. INFORMANT AND ADDRESS Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio-vascular renal disease — years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — years

(c) Diabetes — years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome due to cerebral arteriosclerosis with psychosis — 4 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-1, 1954, to 8-1, 1954, that I last saw the deceased alive on August 1, 1954, and that death occurred at 7:10 p.m., from the causes and on the date stated above.

SIGNATURE Walter H. Sonnenfeld (Degree or title) M.D. ADDRESS Springfield State Hospital DATE SIGNED 8-2-54

23. BURIAL, CREMATION REMOVAL (Specify) Removal DATE 8-2-54 NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. Aug. 2, 1954 REGISTRAR'S SIGNATURE C. Harry Wen

24. FUNERAL DIRECTOR Wm. Cook, Inc. 1217 St Paul St. Balto. ADDRESS

RECEIVED
AUG 6 1954
BUREAU V. S.

07381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7390 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1. PLACE OF DEATH.
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 2 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 25,
STREET ADDRESS (If rural give location) 247 N. Luzerne Avenue

3. NAME OF DECEASED: (Type or Print) (First) Lucille (Middle) Clara (Last) O'Hara

4. DATE OF DEATH: (Month) August (Day) 31 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH 8-23-1876

9. AGE last birthday 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Lingan

14. MOTHER'S MAIDEN NAME: Mary Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4435

IMMEDIATE CAUSE (A) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSE (S) DUE TO with hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) Arteriosclerotic cardio-vascular disease — Years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. CBS associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-21-54 19 , to 8-31 , 1954, that I last saw the deceased alive on 8-30 , 1954, and that death occurred at 5:45AM, from the causes and on the date stated above.

SIGNATURE Ray H. Hayes M D — ADDRESS Springfield State Hospital — DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial

DATE THEREOF Sept 3, 1954

NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery

LOCATION (City, town, or county) Eastern Ave (State) Md

DATE REC'D BY LOCAL REGISTRAR 9-1-54

REGISTRAR'S SIGNATURE L

24. FUNERAL DIRECTOR Leo G. Cook

ADDRESS 1701 Patterson Pk Ave

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

7391

07382
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
COUNTY Carroll — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gamber
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore City
STREET ADDRESS (If rural, give location) 2019 Ramsay St.

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) E. (Last) PFEIFFER
4. DATE OF DEATH (Month) Aug (Day) 1 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married Mar.	22-1874	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Machinist.
10b. KIND OF BUSINESS OR INDUSTRY: B&O. R.R.
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George E. Pfeiffer
14. MOTHER'S MAIDEN NAME: Ann Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: 705-10-3070
17. INFORMANT & ADDRESS: Mary E. Pfeiffer - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	—
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	
DUE TO		
	(c)	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Raymond F. Mount M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 8/1/54

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Aug. 4-54	Loudon Park.	Balto - Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
8-4-54	Ida Hedin	Wm. B. Illyghart & Son 1300 Eutaw Pl.

Over

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07383 74

7392

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 2months11days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Charles
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pisgah
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) BESSIE (Middle) ARTENE (Last) POSEY

4. DATE OF DEATH: (Month) August (Day) 9 (Year) 1954

5. SEX. Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced
8. DATE OF BIRTH: December 15, 1899
9. AGE last birthday 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10B. KIND OF BUSINESS OR INDUSTRY. None
11. BIRTHPLACE (State or foreign country): Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas A. Dyson
14. MOTHER'S MAIDEN NAME: Mary E. Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH years

ANTECEDENT CAUSE (S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Renal tuberculosis — years

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Psychotic Depressive reaction — 4 months

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21C WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.
21E INJURY OCCURRED While at work [ ] Not while at work [ ]
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-28, 1954 to 8-9-, 1954 that I last saw the deceased alive on 8-9, 1954, and that death occurred at 7:45 AM, from the causes and on the date stated above.

SIGNATURE Ray H. Hayes M.D. ADDRESS M. D. Springfield State Hospital DATE SIGNED 8-9-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF Aug 11 1954
NAME OF CEMETERY OR CREMATORY St Ignatius Cemetery
LOCATION (City, town, or county) (State) Hilltop Md

DATE REC'D BY LOCAL REGISTRAR 8/10/54
REGISTRAR'S SIGNATURE Julia H Pasey Harry Meer
24. FUNERAL DIRECTOR Hurtt & Ryon ADDRESS Waldorf Md

VS. A15 — 10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 12
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07384

7393 **CERTIFICATE OF DEATH** Reg. Dist. No. 74

1 PLACE OF DEATH: COUNTY Carroll MARYLAND	2 USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton; LENGTH OF STAY (in this place) 2yrs.43 days	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 23
HOSPITAL OR INSTITUTION OR STREET ADDRESS Henryton State Hospital	STREET ADDRESS (If rural give location) 128 N. Mount Street

3. NAME OF DECEASED: (Type or Print) (First) Jacob (Middle) Douglas (Last) Rainey

4. DATE OF DEATH: (Month) August (Day) 26 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Seperated

8. DATE OF BIRTH: May 27,1898

9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Lunenburg Co. Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wesley M. Rainey

14. MOTHER'S MAIDEN NAME: Rebecca Harris

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: Lost

17. INFORMANT & ADDRESS: Deceased

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Far advanced bilateral pulmonary tuberculosis — Interval Between Onset And Death 3yrs.9mths.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 14, 1952, to Aug. 26, 1954, that I last saw the deceased alive on Aug. 26, 1954, and that death occurred at 8:00 P.M., from the causes and on the date stated above.

SIGNATURE T.F. Vestal M.D. (Degree or title) ADDRESS Henryton, Maryland DATE SIGNED 8-26-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF Sept. 1, 1954 NAME OF CEMETERY OR CREMATORY New Grove Baptist Church LOCATION (City, town, or county) Kenbridge, Va. (State)

DATE REC'D BY LOCAL REGISTRAR 8-26-54 REGISTRAR'S SIGNATURE Albert R. Swanthams Deputy Local

24. FUNERAL DIRECTOR S. P. Jones ADDRESS Kenbridge, Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

SEP
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

7394 07385

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll Co.

City or town Rural RD#5 Westminster, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll Co.

City or town Nr. Winfield RD#5 Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME HENRY Cleveland Reaver Sr.

3.(b) Social Security Number 217-12-2337

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband~~ or wife ~~Elizabeth Wolbert Reaver~~ Blanche M. Reaver 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1892

8. AGE: Years	Months	Days	If less than one day
62			hrs. min.

9. Birthplace Carroll Co., MD.
(Town, county, and state)

10. Usual occupation Farmer.

11. Industry or business

FATHER
12. Name Elizabeth Wolbert Reaver
13. Birthplace MD

MOTHER
14. Maiden name ~~Henry~~ Henry T. Reaver
15. Birthplace MD.

16. Informant Mr. Blanche Reaver
Address RD#5 Westminster, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-8-54 (month) (day) (year)

Cemetery or ~~crematory~~ Morgan chapel Cemetery

Location Nr. Woodbine, MD.

18. Funeral director C. M. Waltz
Address Winfield, MD.

19. Aug 6 1954 (Date rec'd by registrar) E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6/54 19 at 3:45 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from [illegible] 19 2 to [illegible] 19

and that I last saw h[illegible] alive on [illegible] 19

Immediate cause of death [illegible] DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed [illegible]

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BUREAU U. S.

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MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY: Carroll — STATE: MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
LENGTH OF STAY (in this place): 4 mos. 16days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Talbot
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Easton
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) Rosa (Middle) Agnes (Last) Ross

4. DATE OF DEATH: (Month) August (Day) 2 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 3-16-69

9. AGE last birthday: 85 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dyott

14. MOTHER'S MAIDEN NAME: ? Auld

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY No.: Unk.

17. INFORMANT AND ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchopneumonia — Interval between Onset and Death: 24 hours

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c) Arrested tuberculosis of the lungs — ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with (psychotic reaction, plus far-(advanced active pulm. tuberculosis — 10 years +

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 19 54, to 8-2, 19 54, that I last saw the deceased alive on August 1, 19 54, and that death occurred at 2:03 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Walther H. Sonnenfeldt M.D. ADDRESS: Springfield State Hospital DATE SIGNED: 8/3/54.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 8-5-54 — NAME OF CEMETERY OR CREMATORY: Spring Hill — LOCATION (City, town, or county) (State): Easton, Md.

DATE REC'D BY LOCAL REG.: Aug. 3, 1954 — REGISTRAR'S SIGNATURE: C. Harry Edwards

24. FUNERAL DIRECTOR: Ellis H. Clark — ADDRESS: Easton, Md.

RECEIVED
AUG 6 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7396 **CERTIFICATE OF DEATH** Reg. Dist. No. 07387

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville ✓
LENGTH OF STAY (in this place) 10 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 6,
STREET ADDRESS (If rural give location) 4113 Idaho Avenue

3. NAME OF DECEASED: (Type or Print) (First) ERNEST (Middle) (Last) SCHWEIKERT

4. DATE OF DEATH: (Month) AUGUST (Day) 10 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: Sept. 6-1875

9. AGE last birthday: 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brewery worker

10B. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Schweikart

14. MOTHER'S MAIDEN NAME: Caroline Schreich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

IMMEDIATE CAUSE (A) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSE (S)
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.
DUE TO (B) Broncho pneumonia — 11 days
DUE TO (C) Arteriosclerotic Cardiovascular disease — years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M.

21E. INJURY OCCURRED While at work ☐ Not while at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-30, 1954 to 8-10, 1954 that I last saw the deceased alive on 8-9, 1954, and that death occurred at 5:05 AM, from the causes and on the date stated above.

SIGNATURE Ray V. Hays M.D. M.D. ADDRESS Springfield State Hospital DATE SIGNED 8-10-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial — DATE THEREOF Aug. 13/54 — NAME OF CEMETERY OR CREMATORY Balto. Cemetery — LOCATION (City, town, or county) Balto. (State) Md.

DATE REC'D BY LOCAL REGISTRAR 8-11-54 — REGISTRAR'S SIGNATURE A.W. Hedrick ✓ — 24. FUNERAL DIRECTOR John A. Miller — ADDRESS 2334 Jefferson St.

VS. A15—10-53

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

7397 MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

07388

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Prod. Manchester
LENGTH OF STAY (in this place) 4 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Prod. Manchester
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Ivan (Middle) Jay (Last) Smith

4. DATE OF DEATH (Month) Aug. (Day) 3 (Year) 1954

5. SEX M **6. COLOR OR RACE** W **7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)** Married **8. DATE OF BIRTH** 6 30 1904 **9. AGE** last birthday 50 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter **10b. KIND OF BUSINESS OR INDUSTRY** Building **11. BIRTHPLACE** (State or foreign country) Virginia **12. CITIZEN OF WHAT COUNTRY?** U. S. A.

13. FATHER'S NAME H. F. Smith **14. MOTHER'S MAIDEN NAME** Lillie Yingling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) WW II **16. SOCIAL SECURITY NO.** 214-16-8710 **17. INFORMANT AND ADDRESS** Mrs. Ida M. Smith, Manchester, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive heart failure — Interval between onset and death: one year

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) pulmonary edema

(c) obesity

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. **INJURY OCCURRED** While at Work ☐ Not While At work ☐ **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from ____, 19____, ~~to~~ August 8, 1954 that I last saw the deceased ~~alive~~ dead on August 8, 1954, and that death occurred at 1.40 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Bertrand K Gau M.D. Central Avenue, Sykesville, Md. 8.9.54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE 8-10-54 NAME OF CEMETERY OR CREMATORY Pinemeadow LOCATION (City, town, or county) (State) Finksburg, Md.

DATE REC'D BY LOCAL REG. Aug. 9, 1954 REGISTRAR'S SIGNATURE Catherine G Eline

24. FUNERAL DIRECTOR Wm. H. Mount - Sykesville, Md. ADDRESS

AUG 11 1954

BUREAU U. S.

7398

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist. 07389

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 74

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) —
LENGTH OF STAY (In this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS Route 26.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Carroll
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN [illegible] -- Rural
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (First) MAYNARD (Middle) E. (Last) SMITH
4. DATE OF DEATH (Month) Aug (Day) 22 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: June 12, 1917
9. AGE last birthday: 37 yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Day Laborer
10b. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Howard Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Smith
14. MOTHER'S MAIDEN NAME: Mary Johns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Catherine Lorman, [illegible]

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Fractured Skull — DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) — DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Route 26.
21c. (City or town) Eldersburg (County) Carroll (State) Md
21d. TIME OF INJURY (Month) 8 (Day) 22 (Year) 54 (Hour) 3:30 A.M.
21e. INJURY OCCURRED White at work ☐ Not while at work ☒
21f. HOW DID INJURY OCCUR? Automobile accident

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE James J. Marsh M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐
DATE SIGNED 8/22/54

23. BURIAL, CREMATION, REMOVAL (Specify): [illegible]
DATE THEREOF 8-25-54
NAME OF CEMETERY ~~OR CREMATORY~~ Bush Presbyterian
LOCATION (City, town, or county) (State) Lorraine, Maryland

DATE REC'D BY LOCAL REG. Aug. 24, 1954
REGISTRAR'S SIGNATURE C. Harry Weaver
24. FUNERAL DIRECTOR ADDRESS [illegible]

VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG
BUREAU V. S.

7399 07390

MARYLAND

STATE DEPARTMETT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH
COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville
MARYLAND
LENGTH OF STAY (in this place) 14 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sykesville, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Sykesville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) BENJAMIN (Middle) WHITELY (Last) STONE

4. DATE OF DEATH (Month) AUG. (Day) 8 (Year) 1954

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, (WIDOWED) DIVORCED, (Specify)

8. DATE OF BIRTH 18 May 1876

9. AGE last birthday 78 yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY Carpenter

11. BIRTHPLACE (State or foreign country) Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lemuel Stone

14. MOTHER'S MAIDEN NAME Katherine M. Stone Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO. Unk.

17. INFORMANT AND ADDRESS Mrs Alma Smith - Sykesville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac arrest — Interval between onset and death: 7 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis - Coronary Thrombosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0

19b. MAJOR FINDINGS OF OPERATION 0

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) 0

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY 0

(CITY OR TOWN) 0 (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) 0 m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Aug., 19 54, to ....., 19....., that I last saw the deceased alive on 8 Aug., 19 54, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE Howard E. Hall (Degree or title) M.D. ADDRESS Sykesville, Md DATE SIGNED 8 Aug '54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE 8-12-54

NAME OF CEMETERY OR CREMATORY Holy Cross

LOCATION (City, town, or county) (State) A. A. Co., Md.

DATE REC'D BY LOCAL REG. Aug. 10, 1954

REGISTRAR'S SIGNATURE C. Harry Klee

24. FUNERAL DIRECTOR C. M. Waltz

ADDRESS Winfield, MD.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 12 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07394

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

1. PLACE OF DEATH: COUNTY Carroll MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville
LENGTH OF STAY (in this place) 3 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural give location) 1316 Eutaw Place

3. NAME OF DECEASED: (First) George (Middle) Lane (Last) Taneyhill M.D.

4. DATE OF DEATH: (Month) 8 (Day) 29 (Year) 1954

5. SEX: male | 6. COLOR OR RACE: white | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower | 8. DATE OF BIRTH: 3-21-80 | 9. AGE last birthday: 74 yrs. | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician | 10B. KIND OF BUSINESS OR INDUSTRY: Medicine

11. BIRTHPLACE (State or foreign country): Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Lane Taneyhill

14. MOTHER'S MAIDEN NAME: Carrie Mc Alister

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) not known (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO. Unk —

17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs

ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerotic cardiovascular disease — years

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic brain syndrome due to arteriosclerosis — years.

19A. DATE OF OPERATION: | 19B. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21A. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) M. | 21E. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 28, 1954 to Aug 29, 1954, that I last saw the deceased alive on Aug 28, 1954, and that death occurred at 3 30A M, from the causes and on the date stated above.

SIGNATURE Walther H. Sonnenschein M. D. ADDRESS Springfield State Hospital DATE SIGNED 8/29

23. BURIAL, CREMATION, REMOVAL (Specify) Cremation | DATE THEREOF 8-29-1954 | NAME OF CEMETERY OR CREMATORY CREMATION Greenmount Cem. 9-1-54 | LOCATION (City, town, or county) (State) 1900 Eutaw Place, Balto. Md.

DATE REC'D BY LOCAL REGISTRAR Aug. 29, 1954 | REGISTRAR'S SIGNATURE C. Harry Uber | 24. FUNERAL DIRECTOR ADDRESS J. D. Nuttall - 1900 Eutaw Place

Burial information: phone call from Mitchell 9/1/54 L

Items 8,9: film G169 8-25-54 L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07392

7401 CERTIFICATE OF DEATH Reg. Dist. No. WC

1. PLACE OF DEATH:
COUNTY Carroll MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Finksburg Md
LENGTH OF STAY (in this place) 8 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Finksburg Nursing Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Reisterstown
STREET ADDRESS (If rural, give location) 103 X 3

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) Green (Last) Waters

4. DATE OF DEATH: (Month) August (Day) 21, (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: August 11, 1871

9. AGE last birthday: 83 yrs. IF UNDER 1 YEAR Months – Days 10 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): At Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Harford County, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Thomas Streett

14. MOTHER'S MAIDEN NAME: Virginia Lindsay Galloway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. S.K.Fendall Waters 5301 Springlake Way

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: (INTERVAL BETWEEN ONSET AND DEATH)

331X

Immediate cause (a) Cerebral hemorrhage — 8 days

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) hypertension — 5 yrs

DUE TO

(c) Arteriosclerosis — 5 year

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-30, 19..., to 8-21-54, 19..., that I last saw the deceased alive on 8-20-54, 19..., and that death occurred at ... m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

H. L. Sutell M.D. Reisterstown Md 8-21-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF August 24, 1954

NAME OF CEMETERY OR CREMATORY Christ Church Cemetery

LOCATION (City, town, or county) (State) Forest Hill, Md

DATE REC'D BY LOCAL REGISTRAR 8/23/54

REGISTRAR'S SIGNATURE A W Hedrich J.C.R.

24. FUNERAL DIRECTOR ADDRESS H. H. Mears & Son 8057 Calvert Street

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07393

7402

CERTIFICATE OF DEATH

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Carroll — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sykesville, Maryland

LENGTH OF STAY (in this place) 1yr. 10mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Frederick

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frederick

10-11-2

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Lena	Ione	Wood	8	18	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widow	2-18-1868	86 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Unknown	Unk-	Frederick, Md.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Philemon Griffith	Elizabeth Wood

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
Unk-	----	Unk-	Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331 X

Immediate cause (a) Cerebral hemorrhage — Interval Between Onset And Death: 2 wks.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) General arteriosclerosis — 10 yrs.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. C.B.S. assoc. with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reactio

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
----	----	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
----	----	----		

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
----			m.		----

22. I hereby certify that I attended the deceased from 2-12-, 19 53, to 8-18-, 19 54, that I last saw the deceased alive on 8-18-, 19 54 and that death occurred at 12:55 P.M., from the causes and on the date stated above.

SIGNATURE M. N. Martin, M.D. (Degree or title) — ADDRESS Springfield State Hosp., Sykesville, Md. — DATE SIGNED 8-18-54

23. BURIAL, CREMATION, REMOVAL, (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	8-20-54	New Market Cemetery	New Market	Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
8-20-54	C. Harry Weer	W E Talbert	New Market

RECEIVED
SEP 2 1954
BUREAU V. S.